STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. BUILDING 00 B. WING	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Annual Recertification and State Licensure survey. Survey dates: July 2, 3, 5, 6, 9, 10 and 11, 2012 Facility number: 000026 Provider number: 155066 AIM number: 100274820 Survey team: Toni Maley, BSW, TC Tammy Alley, RN Linn Mackey, RN (7/2, 3, 5, 6/12) Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 14 Medicaid: 51 Other: 11 Total: 76 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 16, 2012 by Bev Faulkner, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified when medications were not available for administration for 4 of 10 residents	F0157	A. The Physicians of residents 94, 7, 60, and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure that	08/06/2012

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	reviewed for medication administration in a sample of 10. (Resident # 94, 7, 60, and 75) Findings include: 1. The record for Resident # 94 was reviewed on 7/9/12 at 2:05 p.m. The May 2012 Medication Administration Record (MAR) indicated Pepcid 20 milligrams (mg) was not available 5/17-5/21 from the pharmacy. The nursing notes between the above dates did not address the medication being unavailable or that the physician was notified. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding physician notification of medication unavailability. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding physician notification of the Pepcid not being available for administration. 2. The record for Resident # 7 was reviewed on 7/6/12 at 8:46 a.m.		all current medications were available for administration. B. All residents have the potential to be affected by this deficient practice. The facility completed an audit of the MAR for the residents who reside in the facility to assure that all current medications and dosages were available for administration. C. Inservice training was provided by the SDC on 7-17-12 on the policy and procedure for handling "medication not available/no supply" and documentation including but not limited to: notification of physician, notification of resident/family, notification of DNS/designee, and communication with the pharmacy. In the event that medication is not available licensed staff will attempt to locate the medication, they will check the Emergency Drug Kit (EDK) for the med. If still unavailable, licensed staff will then contact the pharmacy for stat delivery. Staff will contact the physician, the resident/family, and the DNS/designee. Licensed staff will complete a Medication/Treatment Error Report to document and track the event. MAR audits will be conducted daily by the DNS/designee to assure meds are available and physicians are notified. Those audits will be done daily for 4 consecutive weeks utilizing the MAR Checklist. Those audits will continue	

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	The June 2012 MAR indicated Hydrochlorathiazide (HCTZ) 25 mg was not available on June 20, 21 and 22 for administration. The nursing notes between 6/20-6/22 did not address the HCTZ not being available or that the physician was notified of the missed doses. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding physician notification of medication unavailability. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding physician notification of the HCTZ unavailability for administration. 3. The record for Resident # 60 was reviewed on 7/10/12 at 8:20 a.m. The April 2012 MAR indicated between 4/6-4/20, Risperdal 0.25 mg and Ambien 5 mg was not available for administration. The May 2012 MAR indicated between 5/1-5/6, Zegerid 40/100 mg was not available for administration. The June 2012 MAR between		to be done weekly for 4 additional weeks, then monthly for 2 months, and quarterly thereafter. D. The MAR CQI tool will be completed weekly for 4 weeks, then monthly for 2 additional months, then quarterly thereafter. The results of both audits and the Medication/Treatment Error Reports will be added to the agenda of the monthly CQI meeting for review. The CQI team will create a further plan of action if further issues arise or a threshold score of 90% is not achieved on MAR CQI tool. 8-6-2012	

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	6/20-6/22, indicated Zanaflex 5 mg was not available. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding physician notification of medication unavailability. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding physician notification of the above medications unavailability for administration. During an interview with LPN #10 on 7/11/12 at 1:40 p.m., she indicated if a medication was circled on the MAR, the reason was to be noted on the back of the MAR. If the medication was unavailable from the pharmacy, the pharmacy was to be notified. She indicated the physician was to be notified when a medication is not given. She also indicated the facility had some difficulty receiving mediations timely. Quality Improvement information dated 3/23/12 was provided by the DON (Director of Nursing) on 7/11/12 at 2:15 p.m., which indicated there were many holes and circles on the MARS. An inservice dated 5/8/12			

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	indicated "...If you circle meds (medication) on the MAR, you must notify the MD (physician) and document on the back of the MAR the reason for holding the med...." 4.) Resident #75's record was reviewed on 7/10/12 at 12:53 p.m. Resident #75's current diagnoses included, but were not limited to, a history of CVA (cerebral vascular accident/stroke), dementia with behaviors, anxiety, depression, Alzheimer's disease, anemia, diabetes mellitus, bipolar disorder, gastro-esophogeal reflux disease, seizure disorder and mood disorder. Resident #75 had a current care plan problem/need regarding pain or discomfort. This problem originated 7/25/11. An approach to this problem was to administer medications as ordered. A review of Resident #75's Medication Administration Record for July (1-10), June and May 2012 found medications were not available on the following dates: a.) 6/3/12-Ultram (a pain medication) not available, pharmacy aware.			

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	b.) 6/26/12- Zantac (a medication to address stomach acid or stomach upset) not available c.) 6/27/12-Zantac not available d.) 5/7/12, 8:00 a.m. -Pepcid (a medication to address stomach acid or stomach upset) not available-"pharmacy notified" e.) 5/8/12, 8:00 a.m.- Pepcid not available "pharmacy notified" Resident #75's clinical record lacked any documentation of the resident's physician being notified regarding the lack of available medication and the possible need to alter treatment such as a substitute medication or alternate treatment during the time that the medication was unavailable. During a 7/11/12, 12:55 p.m., interview, the Administrator and Director of Nursing were questioned regarding Resident #75's physician being notified regarding medication availability in May and June 2012. No additional information was provided by the time of exit on 7/11/12 at 3:45 p.m. 3.1-5(a)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to promptly	F0225	A. The facility ensured resident 82 was free from abuse. The allegation made by resident 82 was	08/06/2012

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	notify the Indiana State Department of Health of an allegation of abuse for 1 of 1 resident who met the criteria for abuse investigation. (Resident #82) Findings Include: 1.) Resident #82's record was reviewed on 7/10/12 at 1:17 p.m. Resident #82's current diagnoses included, but were not limited to, mental retardation, psychotic disorder, hallucinations and depressive disorder. Resident #82 had a 6/20/12, 2:12 p.m., Resident Progress Note (R.P.N.) which indicated "Resident stated that 5 white married men came into her room yesterday at 3p (3:00 p.m.) and touched her. One of the men was old the others were younger. Resident was reassured that she was safe." 6/22/12, 4:26 p.m., R.P.N., "IDT [Inter-Disciplinary Team]: SSD [Social Services Director], DNS [Director of Nursing Services], ADNS [Assistant Director of Nursing] and LPD [Life Path Director]: This writer approached by Hillcroft [Provider for		reported 6-25-12. B. All residents have the potential to be affected by this deficient practice. The facility ensured that all allegations of abuse were reported according to policy. QIS "Abuse" section questions were asked of all residents in the facility 6-25-12. C. All staff received inservice training provided by SDC on American Senior Community's Abuse and Prohibition Policy on 7-17-12 including reporting to ISDH. Residents who have alleged abuse will have a complete investigation initiated. This investigation will include interviews with staff, other residents, and family members if necessary. Staff report allegations of abuse to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified immediately and Executive Director reviews to assure reporting to all the appropriate agencies is initiated per ISDH guidelines. All allegations of Abuse, Neglect, and Misappropriation will also be reviewed by the IDT to assure proper reporting is completed. Physician and Family are notified for all allegations of abuse. D. The Abuse Prohibition and Investigation CQI tool will be utilized by facility to monitor compliance to the Abuse Prohibition policy weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter.	

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	services to developmentally disabled individuals] representative on 6/21/12 stating that resident made statement [sic] that a male made inappropriate contact with her and resident felt like she wanted to harm herself. ...The resident reported it was an older fat man with white hair. This writer asked the resident if this was the same incident that we talked about yesterday. Resident stated yes. Resident stated she is familiar with residents in the facility and it is not a resident at this facility. ...believed male to have worked in the maintenance department, however the description of such man is not consistent with any male working at this facility." 6/25/12, 8:00 p.m., R.P.N.,"..received report that was sent to ISDH [Indiana State Department of Health] from OBRA provider [Hillcroft]. ...this SW [Social Worker] interviewed resident about incident reported by OBRA provider. ...Resident,'some guys came in my room.' ...'They took off my clothes and did it to me.' ...They had sex.'..'I told her. And she told the nurse.'..." 2.) Review of a document titled "FW:Sentinel Event-Verification of Immediate Protective Measures		The QIS "Abuse" section questions will be utilized to assure compliance weekly for 4 weeks, then monthly for 2 months and quarterly thereafter. The results of the Abuse Prohibition and Investigation CQI tool and the QIS questions will be added to the agenda of the monthly CQI meeting for review. The CQI team will create a further plan of action if further issues arise or a threshold score of 100% is not achieved on Abuse Prohibition and Investigation CQI tool. E. 8-6-2012	

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	Required" indicated the report was sent: Friday 6/22/12, at 2:52 p.m. to the Life Paths Director by the Bureau of Developmental Disabilities Services (BDDS). The document indicated: "[Resident #82] reported to [Hillcroft worker's name] that she had been raped the prior day (6/19/12) around 3:00 in the afternoon. She said the alleged rapist was an employee with Edgewater and described him as a white male with gray hair who was wearing a green shirt and blue pants....[Hillcroft employee's name] went to the [Life Path Director's name], Director of the Life Paths unit where [Resident #82] resides....[Life Path Director] replied yes and that [Resident #82] had told her 5 men raped her. [Hillcroft employee] said that is not what [Resident #82] told her...was similar it varied in the number of males involved." 3.) Review of an undated facility document titled "[Resident #82's name] timeline", which was provided by the Administrator on 7/6/12 at 9:30 a.m., indicated the following: "6/20/12 [name], LPN noticed [Resident #82] sitting in hallway [sic] with a tear at her eye. [Employee			

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	name] asked res if she was ok and resident stated, 'I need to talk to someone.' [Employee name] assisted her into her room and asked resident why she was upset...'5 men came into my room and ...(showed the sign for intercourse). Writer asked resident to wait until she could get [Name of Life Path Director]..." "6/20/12, [Life Path Director] came to room, spoke with resident regarding incident...5 married white men came into her room the previous day and had sex with her. Stated one of the men was old and the others were younger." "6/21/12, 9am, Resident saw Hillcroft rep...stated to her at that time, 'I was raped the other day by a fat white haired married man.'...feared resident wanted to harm herself." Life Path Director made aware of allegation. "6/25/12-ED [Executive Director/ Administrator] made aware at 4:30 pm that reportable made to ISDH [and] Anderson Police Dept [Department] and BDDS office. This report reviewed...description of male in this report was a male wearing green shirt and blu (sic) pants." 4.) During a 7/6/12, 10:00 a.m.,			

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	interview the Administrator indicated the following: a.) The first 6/20/12 reported event was not treated as an allegation of abuse and the abuse protocol followed and reported to ISDH because " the allegation was fantastic not based in reality." Due to the fact that the resident had a history of delusional thought and a past history of false allegations and the fanciful nature of the allegation it was not counted as creditable. b.) The complete investigation involving the interviews or assessments of all residents on the Life Path Unit did not occur until 6/25/12 and the reporting to the Indiana state Department of Health of an allegation of abuse did not occur until 6/25/12. c.) It was the facility policy to report all allegations of abuse to ISDH and to investigate all allegations of abuse. 5.) Review of a current, 2/2010, facility policy titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure", which was provided by the Administrator on 7/6/12 at 9:30 a.m., indicated the following:			

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	"Sexual Abuse-includes but is not limited to, sexual harassment, sexual coercion or sexual assault." "The Executive Director/designee will report all unusual occurrences, which include abuse,within 24 hours of discovery, to the Long Term Care Division of the Indiana sate Department of Health..." 6.) Review of the Indiana State Department of Health Self Reported Intake form indicated the facility Administrator reported an allegation of abuse to Resident #82 on 6/25/12 at 10:11 a.m. The report indicated the alleged event had occurred 6/19/12 and the facility had been aware of the allegation since 6/20/12. 3.1-28(c)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record, review the facility failed to promptly implement the facility's abuse prohibition protocol for 1 of 1 resident who met the criteria for abuse investigation. (Resident #82) Findings Include: 1.) Resident #82's record was reviewed on 7/10/12 at 1:17 p.m. Resident #82's current diagnoses included, but were not limited to, mental retardation, psychotic disorder, hallucinations and depressive disorder. Resident #82 had a 6/20/12, 2:12 p.m., Resident Progress Note (R.P.N.) which indicated "Resident displayed episodes of delusional thinking. Resident stated that 5 white married men came into her room yesterday at 3p (3:00 p.m.) and touched her. One of the men was old	F0226	A. The facility ensured resident 82 was free from abuse. The allegation made by resident 82 was reported 6-25-12. B. All residents have the potential to be affected by this deficient practice. The facility ensured that all allegations of abuse were reported according to policy. QIS "Abuse" section questions were asked of all residents in the facility 6-25-12. C. All staff received inservice training provided by SDC on American Senior Community's Abuse and Prohibition Policy on 7-17-12 including reporting to ISDH. Residents who have alleged abuse will have a complete investigation initiated. This investigation will include interviews with staff, other residents, and family members if necessary. Staff report allegations of abuse to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified immediately and Executive Director reviews to assure reporting to all the appropriate agencies is initiated per ISDH guidelines. All allegations of Abuse, Neglect, and Misappropriation will	08/06/2012

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	the others were younger. Resident was reassured that she was safe. This writer was out in the unit at 3p yesterday and did not see a group of unfamiliar men on the unit. Resident was upset today because she was not able to go on a [name] outing. This could attribute to resident [sic] delusional thinking. Resident has behavior care plan regarding delusional episodes." 6/21/12, 9:36 a.m., R.P.N., "Resident made comments this morning that she felt like she wanted to perform a suicide attempt. ...Resident seen by Psychologist....resident placed on 15 min checks for 72 hours." 6/22/12, 4:26 p.m., R.P.N., "IDT [Inter-Disciplinary Team]: SSD [Social Services Director], DNS [Director of Nursing Services], ADNS [Assistant Director of Nursing] and LPD [Life Path Director]: This writer approached by Hillcroft [Provider for services to developmentally disabled individuals] representative on 6/21/12 stating that resident made statement (sic) that a male made inappropriate contact with her and resident felt like she wanted to harm herself. ...The resident reported it was an older fat man with white hair. This writer asked the resident if this was the		also be reviewed by the IDT to assure proper reporting is completed. Physician and Family are notified for all allegations of abuse. D. The Abuse Prohibition and Investigation CQI tool will be utilized by facility to monitor compliance to the Abuse Prohibition policy weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter. The QIS "Abuse" section questions will be utilized to assure compliance weekly for 4 weeks, then monthly for 2 months and quarterly thereafter. The results of the Abuse Prohibition and Investigation CQI tool and the QIS questions will be added to the agenda of the monthly CQI meeting for review. The CQI team will create a further plan of action if further issues arise or a threshold score of 100% is not achieved on Abuse Prohibition and Investigation CQI tool. E. 8-6-2012	

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	same incident that we talked about yesterday. Resident stated yes. Resident stated she is familiar with residents in the facility and it is not a resident at this facility. ...believed male to have worked in the maintenance department, however the description of such man is not consistent with any male working at this facility." 6/25/12, 8:00 p.m., R.P.N.,"..received report that was sent to ISDH [Indiana State Department of Health] from OBRA provider [Hillcroft]. This report incident has variances from issue that resident discussed with staff thus this SW [Social Worker] interviewed resident about incident reported by OBRA provider. ...Resident,'some guys came in my room.' ...'They took off my clothes and did it to me.' ...They had sex.'..'I told her. And she told the nurse.'...After said report was reviewed and [resident's name] and staff were interviewed SW has founded (sic) this issue reported by (OBRA provider) to be same incident reported to staff on 6/20/12 and to OBRA provider on 6/21/12, however resident has varying accounts of information about this issue. 2.) Review of a document titled			

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	"FW:Sentinel Event-Verification of Immediate Protective Measures Required" indicated the report was sent: Friday 6/22/12, at 2:52 p.m. to the Life Paths Director by the Bureau of Developmental Disabilities Services (BDDS). The document indicated: "Please ensure that immediate protective measures are in place." "[Resident #82] reported to [Hillcroft worker's name] that she had been raped the prior day (6/19/12) around 3:00 in the afternoon. She said the alleged rapist was an employee with Edgewater and described him as a white male with gray hair who was wearing a green shirt and blue pants....[Hillcroft employee's name] went to the [Life Path Director's name], Director of the Life Paths unit where [Resident #82] resides....[Life Path Director] replied yes and that [Resident #82] had told her 5 men raped her. [Hillcroft employee] said that is not what [Resident #82] told her...was similar it varied in the number of males involved." "Plan to Resolve: Hillcroft has followed BDDS reporting procedures, contacted local police and completed the Indiana State Department of			

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Health (ISDH) Incident Report Form for Reasonable Suspicion of a Crime against a Resident."

3.) Review of an undated facility document titled "[Resident #82's name] timeline", which was provided by the Administrator on 7/6/12 at 9:30 a.m., indicated the following:

"6/20/12 [name], LPN noticed [Resident #82] sitting in hallway (sic) with a tear at her eye. [Employee name] asked res if she was ok and resident stated, 'I need to talk to someone.' [Employee name] assisted her into her room and asked resident why she was upset...'5 men came into my room and ...(showed the sign for intercourse). Writer asked resident to wait until she could get [Name of Life Path Director]..."

"6/20/12, [Life Path Director] came to room, spoke with resident regarding incident...5 married white men came into her room the previous day and had sex with her. Stated one of the men was old and the others were younger. ...placed resident on hot charting for delusional thinking..d/t dx of Psychotic disorder with delusions."

"6/21/12, 9am, Resident saw Hillcroft

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	rep...stated to her at that time, 'I was raped the other day by a fat white haired married man.'...feared resident wanted to harm herself." Life Path Director made aware of allegation. "6/25/12-ED [Executive Director/ Administrator] made aware at 4:30 pm that reportable made to ISDH [and] Anderson Police Dept [Department] and BDDS office. This report reviewed...description of male in this report was a male wearing green shirt and blu (sic) pants." "6/29/12-...Anderson PD came in, reviewed care plan, or investigation and psychiatric history and closed police investigation." 4.) During a 7/6/12, 10:00 a.m., interview the Administrator indicated the following: a.) The first 6/20/12 reported event was not treated as an allegation of abuse and the abuse protocol followed and reported to ISDH because " the allegation was fantastic not based in reality." Due to the fact that the resident had a history of delusional thought and a past history of false allegations and the fanciful nature of the allegation it was not			

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	counted as creditable. b.) After the 6/25/12 information by the OBRA provider, the allegation was more creditable and the facility abuse protocol was then initiated. c.) The complete investigation involving the interviews or assessments of all residents on the Life Path Unit did not occur until 6/25/12 and the reporting to the Indiana state Department of Health of an allegation of abuse did not occur until 6/25/12. d.) It was the facility policy to report all allegations of abuse to ISDH and to investigate all allegations of abuse. 5.) Review of a current, 2/2010, facility policy titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure", which was provided by the Administrator on 7/6/12 at 9:30 a.m., indicated the following: "Sexual Abuse-includes but is not limited to, sexual harassment, sexual coercion or sexual assault." "The Executive Director/designee will report all unusual occurrences, which include abuse,within 24 hours of			

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	discovery, to the Long Term Care Division of the Indiana sate Department of Health..." 6.) Review of the Indiana State Department of Health Self Reported Intake form indicated the facility Administrator reported an allegation of abuse to Resident #82 on 6/25/12 at 10:11 a.m. The report indicated the alleged event had occurred 6/19/12 and the facility had been aware of the allegation since 6/20/12. 3.1-28(a)			

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F0253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based observation and interview, the facility failed to ensure 6 of 40 resident rooms including bathrooms,(Rooms 101, 106, 110, 108, 113, and 107) and 1 of 3 shower room floors were in good repair and clean. Finding include: Between 7/2/12 and 7/3/12, the following was observed in the listed resident rooms: Room 101: The bathroom wall to the right had 2 large areas of chipped paint 12 inches up from floor and brown staining around the toilet base and hard water staining on the faucet. Room 106: The bathroom wall to the right of the door had a large area of chipped and marred drywall approximately 12-18 inches up from the floor. The interior side of the bathroom door had scuffing the width of the door approximately 12 inches up from the floor.	F0253	A. Resident Rooms and bathrooms 101, 106, 107, 108, 110, and 113 were cleaned, sanitized, and paint was touched up immediately during survey. The Life Path Shower room was cleaned and sanitized. B. All resident rooms and bathrooms were cleaned, sanitized, and reviewed for repair during survey. The remaining shower rooms were also cleaned and sanitized. C. Facility Maintenance Staff including supervisor received inservice training on 7-27-12 by the Executive Director regarding routine maintenance expectation for resident rooms and common areas including shower rooms. Housekeeping Staff including supervisor received inservice training on 7-27-12 by Executive Director regarding housekeeping expectations for patient rooms and common areas including shower rooms. D. Maintenance of sanitary, orderly, and comfortable conditions will be monitored by through use of Housekeeping Procedure's "Daily Housekeeping", "Restroom Cleaning", and "Detail Cleaning" checklists. The "Daily	08/06/2012

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	Room 110: The left wall had marring and black marking 3-3 1/2 feet up the wall 6-7 feet wide and 4 inches deep. The cove board to the left of the bathroom door was pulling away from the wall. The air conditioner vent was out of place. The cove base around the bathroom floor was pulling away and down in one spot along the entire wall. Room 108: There was brown staining on floor around the bathroom toilet Room 113: The corner of the wall by the bathroom had marred and chipped dry wall and the cove board along the wall was pushed in the width of 1 1/2 tile. Room 107: There was 2 areas of marring behind the toilet and hard water build up on the faucet. 2.) During an environmental tour on 7/6/12 at 10:00 a.m., with the Maintenance Supervisor and Housekeeping Supervisor, the Life Path bathing/shower room was observed to have a white tile floor. The grout in the floor was noted to be discolored throughout the room. The		Housekeeping" checklist will be completed on 10 resident rooms and 1 shower room daily by the Housekeeping Supervisor for 4 weeks, then weekly for 1 month by the Executive Director, then monthly for 2 months by the Executive Director, then quarterly thereafter utilizing the Physical Environment CQI. Additionally, the Room Readiness Checklist will be completed by the Maintenance Supervisor on 10 rooms and 1 shower room daily for 4 weeks, then weekly for 1 month by the Executive Director, and then monthly for 3 months by the Executive Director, then quarterly thereafter utilizing the Physical Environment CQI. The CQI team will develop further action plans should threshold score of 90% not be achieved. E. 8-6-2012	

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	discoloration was in shades of black, gray and white. During a 7/6/12 at 11:30 a.m., interview with the Housekeeping Supervisor, she indicated there was no policy for cleaning the gout in the tile floor. The Supervisor indicated the facility does deep clean the floor once a month and does so using the instructions in the training manual for floor care. The Housekeeping Supervisor also indicated she has talked to the corporation about getting different chemicals to clean the tile floors. 3.1-19(f)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure a resident was not started on a routine daily hypnotic medication without first attempting non-chemical interventions to aid sleeping and an assessment of sleep preference and possible causes for sleep disturbances were completed for 1 of 10 residents reviewed for unnecessary medications (Resident #10).	F0329	A. Resident 10's attending physician was contacted to review the order for routine hypnotic (Ambien 10mg). Physician changed the order from routine to PRN. Non-chemical interventions for Resident 10 were put into place to assure no unnecessary doses are administered. Resident 10 is adequately monitored for use of hypnotic medication. B. All residents have the potential to be affected by this deficient practice. The clinical records of resident receiving	08/06/2012

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	Findings Include: Resident #10's record was reviewed on 7/10/12 at 2:30 p.m. Resident #10 was admitted to the facility on 3/30/12. Resident #10's current and admission diagnoses included, but were not limited to, unspecific psychosis, bipolar disorder, adjustment disorder with anxiety, diabetes mellitus, depression and dementia. At the time of admission Resident #10 did not have orders for a hypnotic/sleep aiding medication. Review of Resident #10's orders from his previous nursing home placement indicated he was not taking a hypnotic while residing in that facility. Resident #10 had a 4/8/12, one time order for Ambien 10 mg (a hypnotic or sleep aiding medication) today at bedside. Resident #10 had a current, 4/13/12, physician's order for Ambien 10 mg (a hypnotic or sleep aiding medication) daily at bedtime for insomnia. This order continued to be in place on 7/10/12.		hypnotics medications have been reviewed to ensure the medications are medically necessary. The audit included care plan, C.N.A need sheet, behavior monitoring form for appropriate interventions. All staff were provided inservice training on 7-17-12 by SDC regarding the use of non-pharmacological interventions and alternatives to the use of hypnotics C. All staff were provided inservice training on 7-17-12 by SDC regarding the use of non-pharmacological interventions and alternatives to the use of hypnotics. The psychotropic medication management program was reviewed with licensed nurses by the Director of Social Services or designee. Residents exhibiting symptoms of insomnia are discussed daily in IDT meeting. This will ensure that appropriate non-pharmaceutical interventions are in place and monitoring is initiated. All new orders for hypnotics will be reviewed daily at morning meeting to ensure hypnotics are ordered only as needed and that non-pharmacological interventions are in place, utilized, and documented prior to medication administration. D. The Psychoactive/Behavior Management CQI tool will be utilized weekly for 1 month, then monthly for 3 months then quarterly	

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	Resident #10's Resident Progress Notes (R.P.N.) were limited to the following documentation related to sleep: a.) 4/2/12, 4:55 a.m., R.P.N., "excessive use of call light,... awake most of shift." b.) 4/8/12, 8:52 p.m., R.P.N., "...res [resident] has a hx [history] of staying up all night [and] not sleeping." c.) 4/10/12, 2:46 a.m., R.P.N., "...repetitive call light use, awake through out this shift with short naps at a time.' d.) 4/13/12, 6:14 a.m., R.P.N., "Resident awake all noct, [night] asking 'what time is it', tried repositioning numerous times, Res [resident] just rolled on his back.' e.) 4/13/12, 8:57 a.m., R.P.N., "IDT [Intra-disciplinary Team] discussed different options to help [resident's name] sleep better at night...nursing is requesting sleep aid." Resident #10's record lacked: a.) Documentation if Resident #10 was allowed the opportunity to be up		thereafter. The CQI team will review data. If the threshold of 90% compliance is not met then an action plan will be developed and monthly audits continued. New orders for hypnotics along with other psychotropic medications will be reviewed monthly for 3 months and then quarterly as part of the monthly CQI meeting. Each resident utilizing these medications will have their non-pharmaceutical interventions reviewed monthly for 3 months and then quarterly as part of CQI. E. 8-6-2012	

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	out of bed when he was awake. b.) Documentation if Resident #10 desired to sleep at night or would prefer to sleep at another time. c.) Documentation Resident #10 was assessed for other causative factors that were interrupting sleep such as light, noise, temperature, excess consumption of caffeine, etc. d.) Documentation of the resident having sleep disturbances other than the above four notes. e.) Documentation that other non-chemical interventions other than repositioning had been attempted prior to the introduction of a sleep aid, such as back rubs, warm milk, soft music, pain assessments, etc. During a 7/10/12, 3:05 p.m., interview, the Social Service Director indicated that other than offering repositioning no other non-chemical interventions had been documented as attempted prior to placing the resident on a routine hypnotic medication. She additionally indicated Resident #10 had not been offered an as needed sleep aid which he could request on nights he felt he could not sleep. She indicated an			

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	assessment had not been completed to determine if Resident #10 was a night time sleeper or preferred to sleep at other times of the day and be awake at night. She also indicated there was no documentation of an assessment to ensure other reasons for the residents sleep disturbance had been ruled out. Review of a current, undated, facility policy titled "ASC [American Senior Communities] Psychotropic Medication Management Program", which was provided by the R.N. Consultant on 7/10/12 at 4:20 p.m., indicated the following: "Sedative/Hypnotics must have a diagnoses of insomnia or sleep disorder. There should also be evidence that other reasons for sleep disturbance have been ruled out." 3.1-48(b)(2)			

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F0425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure medications were available for administration for 4 of 10 resident medication reviews in a sample of 10. (Resident # 94, 7, 60, and 75) Findings include: 1. The record for Resident # 94 was reviewed on 7/9/12 at 2:05 p.m. The May 2012 Medication Administration Record (MAR) indicated Pepcid 20 milligrams (mg) was not available 5/17-5/21 from the	F0425	A. The Physicians of residents 94, 7, 60, and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure that all current medications were available for administration. B. All residents have the potential to be affected by this deficient practice. The facility completed an audit of the MAR for the residents who reside in the facility to assure that all current medications and dosages were available for administration. C. Inservice training was provided by the SDC on 7-17-12 on	08/06/2012

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	pharmacy. The nursing notes between the above dates did not address the medication being unavailable or that the physician was notified. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding the medication unavailability. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding the above Pepcid not being available for administration. 2. The record for Resident # 7 was reviewed on 7/6/12 at 8:46 a.m. The June 2012 MAR indicated Hydrochlorothiazide (HCTZ) 25 mg was not available on June 20, 21 and 22 for administration. The nursing notes between 6/20-6/22 did not address the HCTZ not being available or that the physician was notified of the missed doses. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m.,		the policy and procedure for handling "medication not available/no supply" and documentation including but not limited to: notification of physician, notification of resident/family, notification of DNS/designee, and communication with the pharmacy. In the event that medication is not available licensed staff will attempt to locate the medication, they will check the Emergency Drug Kit (EDK) for the med. If still unavailable, licensed staff will then contact the pharmacy for stat delivery. Staff will contact the physician, the resident/family, and the DNS/designee. Licensed staff will complete a Medication/Treatment Error Report to document and track the event. MAR audits will be conducted daily by the DNS/designee to assure meds are available and physicians are notified. Those audits will be done daily for 4 consecutive weeks utilizing the MAR Checklist. Those audits will continue to be done weekly for 4 additional weeks, then monthly for 2 months, and quarterly thereafter. D. The MAR CQI tool will be completed weekly for 4 weeks, then monthly for 2 additional months, then quarterly thereafter. The results of both audits and the Medication/Treatment Error Reports will be added to the agenda of the monthly CQI meeting for review. The CQI team will create a further	

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	regarding the medication unavailability. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding the above HCTZ not being available for administration. 3. The record for Resident # 60 was reviewed on 7/10/12 at 8:20 a.m. The April 2012 MAR indicated between 4/6-4/20, Risperdal 0.25 mg and Ambien 5 mg was not available for administration. The May 2012 MAR indicated between 5/1-5/6, Zegerid 40/100 mg was not available for administration. The June 2012 MAR between 6/20-6/22, indicated Zanaflex 5 mg was not available. The nursing notes, dated 4/12/11, indicated the family was notified of the need for them to bring in the resident's medication. No other documentation for April indicated the family was notified again or any other attempt was made to obtain the residents medication, On 5/11/12 at 2:41 p.m., the nursing		plan of action if further issues arise or a threshold score of 90% is not achieved on MAR CQI tool. E. 8-6-2012	

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	notes indicated the resident's girlfriend was contacted about his medication renewals and she stated she would order his medications from the pharmacy on this date. On 6/22/12, the nursing notes indicated the family was notified to pick up the resident's needed medications. Additional information was requested from the Assistant Director of Nursing (ADON) on 7/10/12 at 10:35 a.m., regarding the medication unavailability. During interview on 7/10/12 at 10:58 a.m., the ADON indicated the pharmacy informed the facility the Zanaflex was ordered at a dose that did not exist so she had personally talked to the Nurse Practitioner and the order was changed on 6/22/12 and the first dose given on 6/23/12. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any physician notification of the resident not getting the above medications. She indicated there was documentation that the family was notified but did not bring in the medication.			

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	During an interview with LPN #10 on 7/11/12 at 1:40 p.m., she indicated if a medication was circled on the MAR, the reason was to be noted on the back of the MAR. If the medication was unavailable from the pharmacy, the pharmacy was to be notified. She indicated the physician was to be notified when a medication is not given. She also indicated the facility had some difficulty receiving mediations timely. Quality Improvement information, dated 3/23/12, was provided by the DON (Director of Nursing) on 7/11/12 at 2:15 p.m., which indicated there were many holes and circles on the MARS. An inservice, dated 5/8/12, indicated "...If you circle meds (medication) on the MAR, you must notify the MD (physician) and document on the back of the MAR the reason for holding the med...." 4.) Resident #75's record was reviewed on 7/10/12 at 12:53 p.m. Resident #75's current diagnoses included, but were not limited to, a history of CVA (cerebral vascular accident/stroke), dementia with behaviors, anxiety, depression, Alzheimer's disease, anemia,			

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	diabetes mellitus, bipolar disorder, gastro-esophogeal reflux disease, seizure disorder and mood disorder. A review of Resident #75's Medication Administration Record for July (1-10), June and May 2012 found medications were not available on the following dates: a.) 6/3/12-Ultram (a pain medication) not available, pharmacy aware. b.) 6/26/12- Zantac (a medication to address stomach acid or stomach upset) not available c.) 6/27/12-Zantac not available d.) 5/7/12, 8:00 a.m. -Pepcid (a medication to address stomach acid or stomach upset) not available-"pharmacy notified" e.) 5/8/12, 8:00 a.m.- Pepcid not available "pharmacy notified" During a 7/11/12, 10:00 a.m., interview the Director of Nursing indicated the facility had been experiencing a problem regarding medication availability and the current pharmacy.			

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	3.1-25(a)			

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F0465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, the facility failed to ensure 2 of 2 medication rooms were clean. This deficient practice had the potential to impact 76 of 76 residents. Finding include: On 7/6/12 at 9:27 a.m., during an observation with LPN # 11 in the Golden Orchard and Moving Forward medication room, the following was observed: The sink was discolored and the faucet had lime build-up. The countertop was stained and discolored with missing caulking around the wall. The wall opposite the entry door had scuffed and marred paint and dry wall approximately 5 feet in width and 6 inches in length. During an observation of the Life Path medication room with LPN # 12, the floor around the cove board had a build-up of dirt and debris and the sink and faucet had a build-up of hard water stains. 3.1-19(f)	F0465	A. The medication rooms on Golden Orchard and Life Path were cleaned and sanitized and paint was touched up immediately during survey. B. All residents have the potential to be affected by this delinquent practice. The medication rooms on Golden Orchard and Life Path were cleaned and sanitized and paint was touched up immediately during survey. Both Medication Rooms had counter top, sink, and faucet fixtures replaced. A new backsplash was installed. Walls were refinished and painted. Cove base was repaired or replaced in both Medication storage rooms. C. Facility Maintenance Staff including supervisor received inservice training regarding routine maintenance expectation for medication storage areas. All staff received inservice training 7-27-12 by the Executive Director regarding how to alert Maintenance Department to needed repairs. D. The Medication Storage rooms will be inspected visually by the Director of Maintenance weekly for 4 weeks. The Medication Storage Rooms will be inspected visually by the Executive Director weekly for 1 month then monthly	08/06/2012

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			for 3 months, then quarterly thereafter utilizing the Physical Environment CQI. If the ED rounds threshold of 90% compliance is not met, the CQI team will develop further action plan to address. E. 8-6-2012	

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F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to implement an effective plan of action to address medication availability. This deficient practice impacted Residents # 94, 7, 60, and 75. Findings include: During a 7/11/12, 12:55 p.m., the Administrator and the Director of	F0520	A. The CQI Committee addressed and will continue to address issues related to Medication Availability. The Physicians of residents 94, 7, 60, and 75 were notified of the individual issue of medications not being available and an audit of the Medication Administration Record (MAR) was completed to assure that all current medications were available for administration. B. The CQI Committee addressed and will continue to address issues related to Medication Availability.	08/06/2012

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	Nursing were interviewed regarding the QAA Committee identifying and developing a plan to address availability of medications and the following concerns. a.) The record for Resident # 94 was reviewed on 7/9/12 at 2:05 p.m. The May 2012 Medication Administration Record (MAR) indicated Pepcid 20 milligrams (mg) was not available 5/17-5/21 from the pharmacy. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding the Pepcid not being available for administration. b.) The record for Resident # 7 was reviewed on 7/6/12 at 8:46 a.m. The June 2012 MAR indicated Hydrochlorathiazide (HCTZ) 25 mg was not available on June 20, 21 and 22 for administration. During interview on 7/10/12 at 4 p.m., the ADON indicated she was unable to locate any information regarding the HCTZ not being available for administration.		All residents have the potential to be affected by this deficient practice. The facility completed an audit of the MAR for the residents who reside in the facility to assure that all current medications and dosages were available for administration. C. The CQI committee continues to address through action plan issues and concerns identified by benchmarking scores within its CQI process, and specifically Medication Availability. Inservice training was provided by the SDC on 7-17-12 on the policy and procedure for handling "medication not available/no supply" and documentation including but not limited to: notification of physician, notification of resident/family, notification of DNS/designee, and communication with the pharmacy. In the event that medication is not available licensed staff will attempt to locate the medication, they will check the Emergency Drug Kit (EDK) for the med. If still unavailable, licensed staff will then contact the pharmacy for stat delivery. Staff will contact the physician, the resident/family, and the DNS/designee. Licensed staff will complete a Medication/Treatment Error Report to document and track the event. MAR audits will be conducted daily by the DNS/designee to assure meds are available and physicians are notified.	

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	c.) The record for Resident # 60 was reviewed on 7/10/12 at 8:20 a.m. The April 2012 MAR indicated between 4/6-4/20, Risperdal 0.25 mg and Ambien 5 mg was not available for administration. The May 2012 MAR indicated between 5/1-5/6, Zegerid 40/100 mg was not available for administration. The June 2012 MAR between 6/20-6/22, indicated Zanaflex 5 mg was not available. During interview on 7/10/12 at 10:58 a.m., the ADON indicated the pharmacy informed the facility the Zanaflex was ordered at a dose that did not exist so she had personally talked to the Nurse Practitioner and the order was changed on 6/22/12 and the first dose given on 6/23/12. d.) Resident #75's record was reviewed on 7/10/12 at 12:53 p.m. Resident #75's current diagnoses included, but were not limited to, a history of CVA (cerebral vascular accident/stroke), dementia with behaviors, anxiety, depression, Alzheimer's disease, anemia, diabetes mellitus, bipolar disorder,		Those audits will be done daily for 4 consecutive weeks utilizing the MAR Checklist. Those audits will continue to be done weekly for 4 additional weeks, then monthly for 2 months, and quarterly thereafter. D. The MAR CQI tool will be completed weekly for 4 weeks, then monthly for 2 additional months, then quarterly thereafter. The results of both audits and the Medication/Treatment Error Reports will be added to the agenda of the monthly CQI meeting for review. The CQI team will create a further plan of action if further issues arise or a threshold score of 90% is not achieved on MAR CQI tool. E. 8-6-2012	

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	gastro-esophogeal reflux disease, seizure disorder and mood disorder. A review of Resident #75's Medication Administration Record for July (1-10), June and May 2012 found medications were not available on the following dates: a.) 6/3/12-Ultram (a pain medication) not available, pharmacy aware. b.) 6/26/12- Zantac (a medication to address stomach acid or stomach upset) not available c.) 6/27/12-Zantac not available d.) 5/7/12, 8:00 a.m. -Pepcid (a medication to address stomach acid or stomach upset) not available-"pharmacy notified" e.) 5/8/12, 8:00 a.m.- Pepcid not available "pharmacy notified" During a 7/11/12, 10:00 a.m., interview the Director of Nursing indicated the facility had been experiencing a problem regarding medication availability and the current pharmacy. During an interview with LPN #10 on 7/11/12 at 1:40 p.m., she indicated if			

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	a medication was circled on the MAR, the reason was to be noted on the back of the MAR. If the medication was unavailable from the pharmacy, the pharmacy was to be notified. She indicated the physician was to be notified when a medication is not given. She also indicated the facility had some difficulty receiving mediations timely. During an interview on 7/11/12 at 2:15 p.m., the Director of Nursing indicated the QAA committee had identified concerns with "pharmacy services" in March 2012 and a plan or action had been implemented at that time. The March 2012 QAA plan had not successfully addressed the concern in that medication availability remained a concern in April, May and June 2012. 3.1-52(b)(2)			